NOTICE OF REDUNDANCY

The hanging committee of *Sexually Transmitted Infections* wishes to announce that two published papers by van Valkengoed *et al*[1 2] exhibit a degree of overlap. Specifically, the female patients are the same in both papers. They are indistinguishable from the point of population size (5714), age (15–40), setting, participation rate (51%), chlamydia prevalence rate (2.8%; CI 2.1–3.4%), and the number of women excluded because of never having been sexually active (125). There is also a certain degree of overlap between the two papers in the introduction, methods, results, and discussion sections.

1 Van Valkengoed IGM, Boeke JAP, Moore SA, *et al.* Disappointing performance of literature-derived selective screening criteria for asymptomatic Chlamydia trachomatis infection in an inner-city population. *Sex Transm Dis* 2000;**27**:504–7.
2 Van Valkengoed IGM, Morré SA, van den Brule AJC, *et al.* Low diagnostic accuracy of selective screening criteria for asymptomatic Chlamydia trachomatis infections in the general population. *Sex Transm Inf* 2000;**76**:375–80.

Reply

We strongly disagree with your conclusion that we are guilty of duplicate publication. The objectives, analyses, and results presented in the two papers in *Sexually Transmitted Diseases* (paper 1)[1] and *Sexually Transmitted Infections* (paper 2)[2] are completely different and do not resemble each other at all. The aim of paper 1 was to determine the value of currently publicised screening criteria for asymptomatic populations as selection criteria for the general population. A literature review was performed to identify criteria for women. Criteria for men were not available. These criteria were then applied to the female participants in the Amsterdam Screening Study. The diagnostic accuracy of these criteria was then found to be poor. That led to the second research question, which was addressed in paper 2: Could suitable new criteria for selective screening of females and males be derived from our own study population? In paper 2 we report on the development of this new set of selective screening criteria and their diagnostic accuracy. In addition, detailed prevalence data and the results for both men and women non-respondents in the Amsterdam Screening Study were presented.

The papers did not contain references to each other. This was not through intent, but because of the simultaneous process of submission for publication. At the time of submission, there was simply no other "paper" to refer to. When checking the proofs of the papers we should have added "in press" to the references, which we neglected to do. We sincerely apologise for this and will remember to do so in future.

In summary, we believe your verdict of duplicate publication to be unjust and your sanction to be too harsh for the omission of cross references.

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1 Van Valkengoed IGM, Boeke AJP, Morre SA, *et al.* Disappointing performance of literature-derived selective screening criteria for asymptomatic Chlamydia trachomatis infection in an inner-city population. *Sex Transm Dis* 2000;**27**:504–7.
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LETTERS TO THE EDITOR

Prevalence of *Chlamydia trachomatis* IgG antibodies in antenatal patients from Trinidad

EDITOR,—A recent study in Jamaica by Dowe *et al* using cell culture and a direct fluorescence assay (DFA) showed a prevalence of *Chlamydia trachomatis* infection in 47% of gynaecological patients.[1] Unfortunately, there are no comparable data for cell culture and DFA in Trinidad. Moreover, we cannot find any reports on serological studies for *C trachomatis* IgG antibody in the West Indies. In an attempt to shed more light on prevalence of *C trachomatis* IgG antibody in pregnant women in Trinidad, we collected 56 serum specimens (mean age of patients 27 years) with ethics committee approval from one clinic at the general hospital, Port of Spain. As well as testing these sera by an in-house ELISA method based on that described by Ossewaarde *et al*,[2] we also used a commercial ELISA test specific for *C trachomatis* IgG (Savyon Diagnostics, Israel) and the whole inclusion immunofluorescence (WHIF) test as previously described by Richmond and Caul.[3]

All collected sera were stored at −70°C until analysis. Samples were subsequently coded and tested blind in duplicate in laboratories in Sheffield and Bristol. Details of the in-house ELISA test methodology and interpretation of readings using microimmunofluorescence (MIF) serum positive and negative controls were described in Keay *et al*.[4] The commercial ELISA was performed according to the manufacturer's instructions. The WHIF test consisted of chlamydial inclusions of infected mammalian cells with LGV2 mounted on a glass well or coverslip. The WHIF titre is described as the highest dilution of antibody where the inclusion can be clearly seen by fluorescence staining.

For the ELISA tests, results were recorded as positive, negative, or equivocal. For the WHIF test, titres between 1:64 and 1:256 were recorded as such; a low titre was ⩽1:64 and a high titre ⩾1:512.

Twenty five (45%) and 29 (52%) samples were positive for the commercial and in-house ELISA tests respectively. Eighteen (32%) samples had a titre of ⩾512 in the WHIF test, as shown in table 1.

The latter finding is of note. It is accepted that *C trachomatis* is an established pelvic pathogen and in a recent study of 34 women positive for *C trachomatis* IgG (⩾1:128) by ELISA, at laparoscopy 31 (91.2%) were diagnosed as having tubal disease.[5] It is likely that significant damage could be occurring in these patients as a previous study looking at high *C trachomatis* IgG titres showed 46% positive and 8% positive in infertile women with damaged and normal tubes, respectively.[6]

Table 1 Comparison of ELISA and WHIF tests showing the Chlamydia trachomatis IgG antibody titre distribution

WHIF test	Commercial ELISA			In-house ELISA		
	+	Eq	−	+	Eq	−
⩾512	15	1	2	18	−	−
256	3	−	1	3	1	−
128	4	−	−	2	1	1
64	2	−	4	4	1	1
⩽64	1	1	1	2	−	1

Eq = equivocal.

Although these findings are based on relatively small numbers, they are of significant concern if combined with the other most recent study.[1] It would appear that the prevalence rates for *C trachomatis* may well be high and that data presented here suggest possible future PID development and resultant sequelae. It is clear that further studies are warranted and that screening and treatment strategies may be required urgently to curtail considerable morbidity in Trinidad and throughout the West Indies in general.

- High prevalence of *C trachomatis* IgG antibodies in antenatal patients in Trinidad
- Prevalence rates of *C trachomatis* in Trinidad are similar to those from Jamaica
- Good correlation of in-house and commercial ELISA tests with WHIF test
- Urgent need for screening and treatment strategies for *C trachomatis* in West Indies

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1 Dowe G, Smikle M, King SD, *et al.* High prevalence of genital Chlamydia trachomatis infection in women presenting in different clinical settings in Jamaica: implications for control strategies. *Sex Transm Inf* 1999;**75**:412–6.
2 Ossewaarde JM, de Vries A, van den Hoek JAR, *et al.* Enzyme immunoassay with enhanced specificity for detection of antibodies to Chlamydia trachomatis. *J Clin Microbiol* 1994; **32**:1419–26.
3 Richmond ST, Caul EO. Fluorescent antibody studies in chlamydial infections. *J Clin Microbiol* 1975;**1**:345–52.